PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT:	CASE NUMBER:

EMPLOYER'S HEALTH INSURANCE RETURN

1. Name of parent employee:

2. Home address of absent parent employee:
   ☐ Not known

3. ☐ The employee has *no* insurance policies for health care, vision care, or dental care through this employment.

4. ☐ The employee has the following insurance policies covering health care, vision care, and dental care:

Company	Type of policy	Policy No.	Persons insured

Date:

.....
(TYPE OR PRINT NAME OF EMPLOYER)

▶ _____
(SIGNATURE OF EMPLOYER)

Address:

Telephone No.:

5. Return this completed return to the following district attorney within 30 days *(name and address of district attorney)*:

If any insurance coverage lapses, complete the notice below and return a copy to the same district attorney.

NOTICE OF LAPSE IN HEALTH INSURANCE

6. The health insurance listed on the Employer's Health Insurance Return above has
   ☐ lapsed ☐ terminated FOR *(check one)*:
   a. ☐ all persons insured for the following reason *(specify)*:

   b. ☐ the following person *(name)*: for the following reason *(specify)*:

Date:

.....
(TYPE OR PRINT NAME OF EMPLOYER)

▶ _____
(SIGNATURE OF EMPLOYER)

Address:

Telephone No.: